Vol. CVI FEBRUARY, 1912 Number 2

NASHVILLE JOURNAL OF MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor and Proprietor
E. S. McKEE, M. D., Cincinnati, Associate Editor

PUBLISHED MONTHLY - - $1.00 a Year in Advance

Entered at the Post-Office at Nashville, Tenn., as Second-Class Matter

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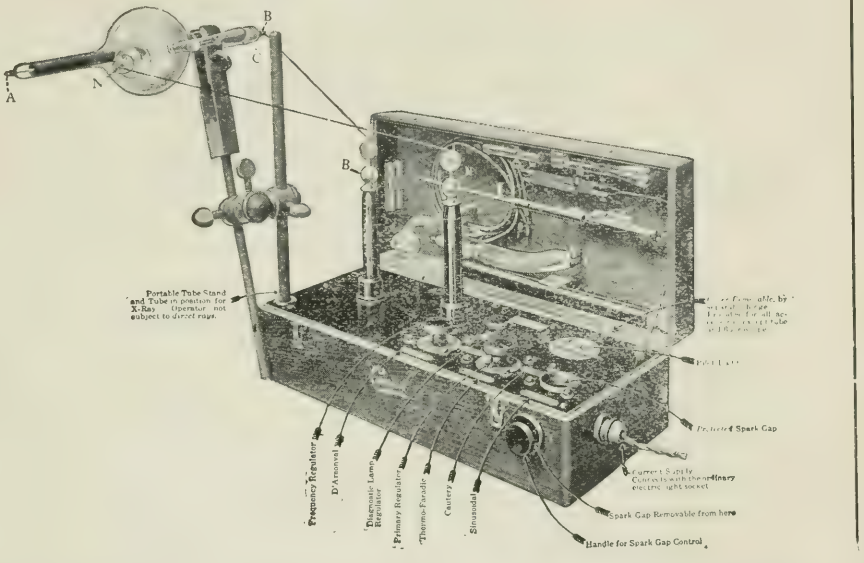

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— OF —
MEDICINE AND SURGERY

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VOL. CVI. FEBRUARY, 1912. No. 2.

Original Communications

STATE BOARD EXAMINATIONS.

BY W. T. BRIGGS, M.D., NASHVILLE, TENN.

State board examinations though a comparatively recent product of legislative activity have already done something toward raising the standards of medical schools. The mere existence of such examinations is bound to have a salutary effect, and because of these examinations many diploma mills have been compelled to close down, but have the examinations per se helped to raise the standard of medical education? Would not some law requiring four years in some reputable medical school do just as much good as these examinations do, without requiring this additional expenditure of time and money on the part of the recent graduate?

We feel that however much these examinations have done, they have not yet reached the point where they carry out the purpose for which they were instituted. This statement does not refer to the examinations of any one or any group of States, but to almost every State in the Union. It seems the greatest good these examinations have done is that the four-year course is insisted on before a graduate can lawfully practice, and in some States, among them Tennessee, there is no such requirement, since a student, after three years in a medical school, can practice, provided he passes the examination satisfactorily, for several months

before his temporary license is null and void. After his fourth year he is given a license without further examination.

If anything ever were inconsistent it is such a law as this, requiring four years in the medical school before allowing a permanent license, and yet giving a temporary license after three years have been passed in the school. It seems that if the applicant is allowed to practice one day he should be allowed to practice until his death without any more schooling or examinations. If men can prepare in three years to pass the State Board, then the college course should be three years, or the State Board of Examiners should raise their standard of examination. While the student-doctor holds this temporary license he might through ignorance cause a death. Likewise he might do the same after one more year of study, but as he is duly qualified that can not be helped. I said duly qualified, but that statement must be modified to read, duly qualified according to the State Board examination. This leads us to the discussion of the weaknesses and shortcomings of most of the State Board examinations. Wherein do they fail to answer the purpose for which they were instituted? In several ways:

First.—In most of the States the examination is a written one and there is little practical about it.

Second.—They do not raise the standard of the medical schools, inasmuch as it would not be difficult for any high school graduate to cram up for two years, even less, and pass the examination. Under such circumstances the crammer would have to know some medicine and surgery, but how much of a practical kind? Almost none.

Third.—There is no examination for those desiring to follow a specialty.

Taking up for discussion caption number one, viz.: "In most of the States the examination is a written one, and there is little practical about it." We find that herein lies the greatest and most palpable weakness of the State Board examinations. Medicine, as practiced, is an art as well as a science, and yet, when we come to the examination, the passing or flunking of which determines whether the graduate of a reputable school is to practice

or not, we find that the art is ignored, and even to a great extent, the science, for in that laboratory technique so necessary for the the present-day practice of medicine, the knowing and the doing are so closely interwoven that only the doing can prove the knowing. An examination on paper of an applicant's laboratory ability is but a poor makeshift for an examination. A student can study up on the blood and *on paper* tell you all that the question calls for, but given a patient and the necessary apparatus and he may make but a poor showing at a blood count, a hæmoglobin test or a differential diagnosis between the blood in simple anæmia and the other anæmias. Perhaps he can tell you all the theories about the formation of urinary casts, and yet have difficulty in telling one cast from another. Or, he can describe in detail Biedert's method of examining sputum for the tubercle bacillus, and yet can not make the examination satisfactorily with all the necessaries at hand.

Again, he can describe the proper dressing for some fracture, and yet, when made to apply it, you may find that he has lost sight of the principle on which this dressing is based, and so will apply a dressing good to look upon and good for that only. He can outline the lungs, heart, spleen and other organs exactly—*on paper*—but given a patient suffering with diseases of one or more of these organs and you will find that many applicants would fail to discover exactly how the outlines had been changed by disease.

We could go on enumerating the weaknesses of the recent graduate in every branch of medicine, but that would be an unnecessary waste of time. It is about the weaknesses of the State Board that we write, for by curing these we can hope to cure those of the student. If we, however, allow them to become greater than they now are, we will find the graduate every year becoming more of a knowledge box, but much less of a practitioner. How can such a state of affairs exist when the schools throughout the country are becoming more and more practical in their curricula?

We grant that this is true, especially in the North, but would like to call your attention to the fact that many graduates of schools, which lay great stress on the practical side in teaching,

either make very poor marks, or flunk outright when they take the examinations in some States. Some of them even flunk after having had a hospital training. All this goes to show that many of the Boards have lost sight of the aim of the examinations, which aim is, first and formost, to find out not just how much the applicant knows, but whether he knows enough to practice medicine with benefit to his patient. They fail to realize that the man who can pick up two lungs and say this one was removed after death occurring during the second stage of pneumonia, while that one is the lung of one who suffered from tuberculosis, knows far more about those diseases than the man who can describe those diseases *on paper* and yet can not tell the pathological condition when he sees it. The former has a good foundation on which he can build, the latter has already a beautiful building, but a weak one.

What chance would most of the older practitioners have against the examinations given today, provided they had no previous preparation? Who would make the better showing, the recent graduate or the old practitioner? Your answer to the second question is, the recent graduate, of course. But if the examination were practical, which would carry the honors? The older, more experienced man, of course. Now, it seems to us that the State Boards of Examiners throughout the country should try to lessen the disparity between the practical and theoretical knowledge of the recent graduate and the practical and theoretical knowledge of the older practitioner, and this can only be done by making as much of the examination practical as is possible. These examinations can be made more practical, should be made more practical, and therefore we offer some suggestions.

In the first place, instead of the examination being held in some official building, they should be held in a hospital connected with some medical school. If the school can not get access to a hospital, then that school should close its doors, for it belongs to another decade. Every branch that has a practical side should have the proper kind of practical examination as well as an oral or written part. We suggest that instead of having the examinations all

written ones, the following at least should have their laboratory or clinical side:

Physiology—Certain experiments should be done in the presence of the applicant, and he should explain the result, or state what the result should be. He should also be made to do some common experiments himself.

Anatomy—Dissections, models, pictures, etc., should be brought in, and the candidate should be made to demonstrate parts with which every graduate should be familiar. He should even be made to dissect a part, demonstrating as he dissects.

Chemistry—Tests in qualitative analysis and other chemical tests.

Materia Medica—Identification of drugs having characteristic appearances.

Pharmacy—Tests in incompatibilities, preparation of some of the commoner Pharmocopeial preparations.

Histology—Should be almost entirely microscopic.

Pathology — He should identify gross specimens of morbid anatomy, and explain the pathology, and the rest of the examination should be almost entirely practical work with the microscope and drawing.

Diagnosis—His ability to outline the organs should be demonstrated on a patient.

Medicine—He should take a case history, make a diagnosis, and prescribe the treatment.

Surgery—Not only should he take a case history, make a diagnosis and outline the treatment, but he should also be required to put on certain bandages and dress wounds. He should also be required to do thoroughly, with special regard to the technique, several operations on the cadaver.

Obstetrics—This can't be made practical in the true sense of the word, because of lack of material. However, an up-to-date manikin should be on hand, and a dead baby, preserved by some injecting fluid, should be used. The applicant can be made to make deliveries both with and without the forceps. This is only a substitute, but a good one. While in Vienna I had courses in Schauta's clinic, and work at the manikin with dead babies was very instructive, and would quickly show off how much the student knew.

Clinical Microscopy—Including Urinalysis, Blood Work, Examinations of Sputum, Gastric Contents, and Feces. This examination should be held in a properly equipped laboratory. In this examination, it seems there should be a time limit and the applicant allowed the use of books inasmuch as he will use books in such work just as soon as he commences to practice. If books were allowed in as many examinations as possible it would impress upon the student that the ability to do things accurately is more important than the ability to learn by rote, and it would also force him to learn to use books quickly and accurately. This is something many don't learn for years after graduation, inasmuch as they are slaves to their notes.

It seems to us that in the branches mentioned above, and perhaps others, the examinations can be made more practical. Of course it is not to be expected that four years in any medical school can develop the tactus eruditus to perfection, nor can the laboratory technique be fully developed in so short a period of time. However, a certain ability to outline organs, recognize pathological conditions, take case histories, dress wounds and make laboratory diagnoses should be a *sine qua non,* and any applicant who doesn't come up to a certain standard in these practical tests should be rejected, no matter how perfect his written examination may have been.

Let us now take up for discussion caption No. 2., viz.: "They don't raise the standard of the medical schools, inasmuch as it would not be difficult for any high school graduate to cram up for two years, perhaps even less, and pass the examination with a good mark." Under such circumstances the applicant would have to know some medicine and surgery, but how much of a practical kind? Very, very little. In order for the State Board examinations to be a force in raising the standard of medical education (and this was one of the purposes for which they were instituted), they must lay stress on the practical and leave the theoretical largely to the schools. Because of this attitude of the examiners we find that the schools have in many places become veritable cramming institutions, teaching didactically what should be taught by practical lessons, and wasting time drilling isolated

facts into the students' heads, when much of that time could have been employed in laboratory and bedside instruction. Demonstrations from patients, cadavers, models, specimens and pictures are often omitted, because the practical knowledge learned from such demonstrations will not pass an applicant without he has in addition the little isolated facts so often required on examinations. It takes time to cram in these facts, because many of them have to be crammed in again and again, since they are of such little practical value that they are forgotten from day to day. Since no school desires its students to fail in the examinations the students are often taught facts of little importance in general practice, the teacher often apologizing with the phrase, "The State Board often asks it."

This desire to make the student thorough in theoretical or rather impractical knowledge is often reflected back from the State Board into the college, and often you will find a question like this in a college examination paper, viz.: name and describe sixteen different methods of detecting sugar in the urine, or give a complete list of the amotile bacteria. Are such questions fair unless you are holding an examination for specialists? It is all very well to know these facts, but aren't there others much more important? If the time the student devoted to learning such "memory developers" were spent in percussing his roommate, putting on bandages, dissecting or operating on the cadaver, etc., wouldn't the student be much better off, both physically and mentally? And, when, after graduation, he made his first professional calls, wouldn't he be better fitted to do his duty?

Because of the questions asked by many State Boards, most schools throughout the country must teach and lay stress on points like the above-mentioned, which could be acquired—if necessary —after graduation. No matter where the college is located, it must prepare the student for all State Board examinations, because few colleges teach students from only one or two States. Students "strain" their brains trying to remember many points only until the examination is over, and are then only too glad to forget them. Why should the successful practitioner know by rote Marsh's test for arsenic, or even four, not sixteen, methods

of detecting sugar. If necessary, he can find Marsh's test in any good book of chemistry, and will naturally choose the most accurate test for sugar in doubtful cases from the existing literature. A regular chemist should make the test for arsenic anyway, since often two lives are at stake, and no chances of a mistake should be taken. It seems to us that the State Boards would ask a more practical question were the applicant asked to tell in detail just how he would act in a case of suspected poisoning.

There is little to say about caption No. 3, viz.: "There is no examination for those desiring to follow a specialty," except that it does seem there should be some special examinations for those who intend to be specialists in order to protect the bona fide specialist in surgery, obstetrics, pediatrics, etc., from others who proclaim themselves specialists without any claims to such a title, no special training and no degree to show that they are better prepared for that line of work than others. Of course it is hardly to be expected that the law require a man to pass a special examination in surgery, or other branches, before proclaiming that his specialty, but the law could require the aspirant to take an examination before he used some degree which would show he was qualified above others to specialize along certain lines. This would protect not only the bona fide specialist, but also the public, for if people employed a pseudo-specialist they would have only themselves to blame.

It is true the State Boards were not instituted with any such direct purpose in view, but they were instituted in order to raise the standard of medical education and to protect the public, and some such provision would, to a great extent, control the "fake" specialist.

There are many specialists eminently qualified in their particular branches, but there are also, as we all know, impostors, working havoc on the ignorant public. If some provision were made whereby a degree should be the distinguishing mark of the specialist, the newspaper advertising specialists would be to a great extent eliminated, because if they advertised without a degree the public would know that they were not all they claimed to be, and so would not fall into the trap set for them.

In closing, we wish to say that this is a criticism of the State Boards only in so far as they are guilty of asking questions, which, under the circumstances, could almost be called foolish. To those Boards which are guilty we make no apology; the others, we feel sure, will agree with us to a certain extent at least, and we even hope this latter group will help bring about the practical examinations in States where at present they don't exist.

Selected Articles

THE PATHOLOGY OF PREGNANCY.*

By Dr. George B. Lawrason, Shreveport, La.

I have chosen my subject, "The Pathology of Pregnancy," because I believed it would be the most interesting and useful one I could think of bringing up before the Society for discussion.

I am well aware that the subject is too extensive for one paper, and for that reason requested members of the Society who wished to read the papers in this section to select some portion of the pathology of pregnancy, so that, as a whole, we should present to the Society a very complete discussion.

The habit of menstruation is established, as a rule, many months before pregnancy occurs, so that unusual contraction and congestion occur at what would have been the menstrual period during a pregnancy.

This enables us to calculate very accurately the date of delivery by counting ten (10) lunar months from date of the last menstruation. Now, as fecundation could have occurred at any time between this last menstruation and the first miss, evidently the delivery must be brought about by that monthly exacerbation of contraction which comes about the time the fetus is ready for expulsion. But this habit which enables us to predict delivery also warns us that, as every monthly period is due, there looms up the danger of miscarriage, greatest with the first month and lessening on succeeding months, as the uterus becomes more tolerant of its burden.

Could we be aware of it, I have no doubt that a large number of miscarriages occur at the first menstruation, and to such of my patients, anxious for children, I have recommended confinement to bed from a day or two before, to the end of what would be the menstrual period. If pregnancy is established, then the slightest pain or show is especially dangerous as each month comes around.

*Read before the Louisiana State Medical Society.

Besides rest, we combat miscarriage according to the prominence of the symptoms of pain and hemorrhage.

I will never forget once in my practice being called to see a patient about three months pregnant who had so much hemorrhage that I thought everything had passed with the clots which had been thrown away before my arrival. Considering that, the only thing to do was to stop the hemorrhage, I gave large doses of ergot, and, much to my astonishment the pregnancy continued after the hemorrhage stopped. On looking up the literature of the subject I found that some masterly articles had been written on the use of ergot in preventing abortion.

Of course, opium in some form is our sheet anchor, and I feel I have obtained very good results with some of the remedies that contain viburnum.

As to when we should use one drug and when the other, the rule is easy—ergot for hemorrhage, opium and viburnum for pain, giving prominence to one or the other drug, according to the prominence of one or the other symptom.

Next, we will take up the nausea and vomiting of pregnancy.

I can not believe any nausea at that time is ever normal, for I have seen patients go through the whole pregnancy without it. In many cases it is only a discomfort; in serious cases it becomes a tragedy.

Many patients become nauseated on rising in the morning on an empty stomach, and the mere precaution of having them stay in bed until a little while after taking their breakfast each morning will be sufficient. On others, we may try every drug we have ever heard of, either internally or locally, to the cervix, without any effect.

Some of these will suffer daily martyrdom cheerfully, upheld by a supreme desire for a child, or by religious scruples, and will run the risk of dying rather than consent to an abortion.

Others may be driven to the verge of insanity by their suffering.

The rule I follow is that where I can not relieve these symptoms, and find a patient losing ground from day to day, I lay the case plainly before husband and wife, telling them of the pos-

sibilities of going through to term safely, as well as of the dangers to be incurred, and let them make their choice.

If, however, albumen should appear in the urine, with the excessive vomiting, then unhesitatingly insist upon abortion as the only hope of the patient. It is a toxemia, and the source of the toxemia can be removed by emptying the uterus. If our patient dies it is because we have not emptied the uterus soon enough.

One case of miscarriage (I have seen a number of such cases) is where a retroverted uterus becomes impregnated. In these cases the fundus does not rise above the promontory of the sacrum and we have first symptoms of bladder irritation from pressure of cervix against the sphincter of the bladder, and, finally, as the uterus grows, the pressure becomes great enough to stop the urinary flow and enormously distend the bladder.

I remember one case, a negro woman, was admitted to the Shreveport Charity Hospital whose bladder reached nearly to the umbilicus. She was immediately catheterized and an enormous amount of urine was drawn. On examination the fundus was found in the hollow of the sacrum, and the os, which pointed toward the bladder, could not be reached by digital examination. The next evening she commenced to have pains and a bloody discharge. The catheter could no longer be introduced; it was impossible to pull the cervix down or push the fundus into the abdomen. She was put on the operating table, the bladder was opened from above, emptied, sewed up with catgut, then the peritoneum was opened, the hand was insinuated under the uterus, which was lifted out of its prison, the wound was closed and the patient made a quick recovery. Afterwards, going to term, a normal pregnancy.

But all cases are not as extreme as this one—by recognizing the condition early enough and placing the patient daily in Alexander's position, pulling the cervix down and pushing the fundus up, we can tide the patient over until the uterus has grown large enough to stay in the upper abdomen.

We now come to one of the great problems of pregnancy—the finding of albumen in the urine.

A woman needs sound kidneys to make a pregnancy safe—

perhaps nature did not intend for toxemia to go with pregnancy, but practically there is more or less toxemia in all pregnancies, and it develops upon the kidneys to excrete this noxious substance Capricious, healthy kidneys may safeguard a patient who has a considerable amount of toxic substance. Crippled ones may get along when there is little of the toxins of pregnancy.

But the average woman stands a poor chance, if she starts childbearing, even with a mild form of chronic nephritis. Do we not treat nephritis by lessening the work of the kidneys? Do we not restrict food and curtail exercise for fear that an acute Bright's may become chronic? How much more should we dread the overwork thrown upon them by pregnancy!

No, a woman with nephritis is too handicapped to subject herself to the perils of motherhood. But if a woman shows albumen in the urine toward the latter half of pregnancy, the question arises: Should we stop that pregnancy? Not necessarily.

Rest and diet to decrease the work of the kidneys. Purgatives to supplement that work will tide many over this perilous time.

However, should convulsions supervene, showing that proper excretion has failed, if we wish to save our patient, the uterus must be emptied at once. Our fight for her life will be none too easy, even with the advantage of having removed the source of the poison.

I will now call your attention to a very important question—When shall we use forceps in labor? I will first ask another question: Do forceps, properly used, cause injury? Remember, I say *properly used.* They should be used with thorough asepsis, also with gentleness; we should not try to pull the child through too contracted a pelvis. I think forceps applied high—that is, in the womb, as is often necessary, have a tendency to produce a greater amount of cervical tear dilating the cervix than the bag of the waters, or even the head of the child in dry labor, so that the greater the delay, consistent with safety to mother and child, the less injury to be expected from their use. There are greater dangers, however, than cervical tears, and forceps applied high are more often called for than after the head has emerged from the cervix.

What shall be our rule? It differs with every patient. No two patients suffer the same amount of pain, no two patients bear the same amount of pain equally well, mentally or physically; therefore the necessity for instrumental interference will differ with every patient.

My first rule is that the patient who needs to be anesthetized before the head is on the perineum should be delivered with forceps. The dangers of anesthesia are, in these cases, very much greater than any injury forceps could be blamed for.

My second rule is that lack of sufficient progress proportionate to the muscular exertion of the uterus, from whatever cause, such as faulty position, small pelvis or a very large child, needs mechanical interference, and we should not wait for the patient to become exhausted before using forceps.

My third rule is that, in any condition necessitating quick delivery, per vaginam, it should be done with forceps.

My fourth rule is that, should we have uterine inertia after the first stage is complete, the danger from continued pressure of the head on the soft walls of the vagina is great, and the application of forceps so easy and harmless we should never hesitate to use them.

As to the placenta, give it plenty of time to come of its own accord. Keep the womb contracted by kneading it. If there is a true adherent placenta—a rare condition—then you can only be certain of removing it by the introduction of the hand in the uterus.

With a contracted, well-emptied uterus, we have no fear of hemorrhage from the placental site, and ergot and manipulation will contract the uterus. But we do have hemorrhage, often copious hemorrhage, under such conditions. Hot-water douching here is mere waste of time. A needle, catgut and needle-holder, is what we need, for such bleeding is from a torn vessel, and your patient is not safe until a suture has been introduced so as to close it.

This brings us to the subject of laceration. When should we mend a laceration? I will not weary you with the arguments of waiting five to seven days after delivery. I was once thoroughly

convinced that it was the right thing to do, and that I had in the past been very wrong in attempting immediate repairs. Gentlemen, my advice to you is to do the best you can at once; your patient won't stand for the other. They want a rest after what they have gone through, and not another operation.

And now a few words about dry labor and I am through. Suppose you have a patient who is dribbling the amniotic fluid during the last month of pregnancy; what are you to do? As far as I know, nothing, except to keep your patient as quiet as possible and await developments. No trouble may come of it, for you may have on your hands a practically normal labor. On the other hand, try to make ready for the worst, as you may have to confront the necessity of Cæsarian section. I have had experience both ways.—*New Orleans Medical and Surgical Journal.*

Extracts from Home and Foreign Journals.

SURGICAL

Chronic Appendicitis.

After a critical study of the post-operative end results in one hundred cases, and a review of the literature the writer arrives at the following conclusions:

(1) The majority of patients suffering from chronic appendicitis give a history of having had one or more attacks of abdominal illness, with a sequence of symptoms recognizable as those of an acute appendix attack, viz., sudden severe abdominal pain, usually beginning in the epigastrium or mid-abdomen, accompanied by nausea and vomiting and followed by a period of pain and tenderness in the right lower quadrant.

(2) "Appendiceal dyspepsia" has been characterized by symptoms strikingly analogous to the earliest symptoms of acute appendicitis, viz., attacks of epigastric or mid-abdominal pain, or distress, only rarely accompanied by subjective symptoms referable to the region of the appendix. During these attacks the pain or distress is nearly always increased by food intake.

(3) Pain confined chiefly to the right lower quadrant and not associated with attacks of epigastric pain and nausea is seldom due to the appendix, and before making a diagnosis of chronic appendicitis in these cases every other possible condition should be excluded.

(4) The majority of failures have been in patients complaining of right inguinal pain associated with chronic constipation. At operation these patients have presented an unusually long or dilated cecum, usually accompanied by other evidences of enteroptosis. In the future a certain proportion of these patients may be cured by some such operation as that advocated by Wilms, but appendicectomy alone does not cure.

(5) Unless the diagnosis is absolutely certain, the gall-bladder, stomach, and right kidney should be explored, and the possibility of a Lane's kink excluded in all cases operated upon for chronic appendicitis.—*American Medicine.*

Pituitary Extract After Abdominal Operations.

The author employed this drug in twenty-one unselected laparotomy cases. In two cases the dose given was ½ c.c. (8 minims), commenced twelve hours after the operation and given every four hours for three days. In the other cases the dose was increased to 1 c.c. (16 minims) for adults. It was commenced about six hours after operation and repeated every four hours until eighteen doses had been given.

From the result of the injections the author considers it evident that pituitary extract has a very marked effect upon the muscular coats of the bowel, and that it is able to overcome the temporary paralysis due to their exposure at the time of operation. This is shown by the early passage of flatus and absence of abdominal discomfort. In only three cases did the bowels act without the assistance of an enema, but in every case except two a satisfactory action of the bowels was obtained after a simple enema, and it was unnecessary to give any aperient by the mouth. All the patients passed flatus freely within a few hours of the first injection, and were free from any abdominal pain or distention. The pulse rate remained much lower than usual, and after some of the most severest operations it did not exceed eighty per minute. Except in the last two cases, no patient suffered from post-operative retention of urine, and so catheterization was unnecessary.

The patients treated with injections of pituitary extract after operations are more generally comfortable, the author states, than those who do not receive them. He does not consider, however, that the drug can be relied on completely to empty the bowels without the assistance of enemata, and, therefore, does not think it need be employed after the first twenty-four hours. He recommends three injections of 1 c.c. each during the first twenty-four hours as a routine practice after laparotomy. They must be made into a muscle, subcutaneous injections causing pain. The first should be given six hours after operation, and the other two at six-hour intervals. No further injections need be given unless there is distention. Suppuration at the site of injection (into

the biceps) was the only unpleasant symptom the author witnessed. No general symptoms were ever produced.—*Monthly Cyclopedia and Medical Bulletin.*

Successful Ligation of the Pulmonary Vein of the Left Lower Lobe for Shot Wound.

Heile reports the second case of this type, the first having occurred in von Eiselsberg's practice several years ago. The natural termination of these cases is death, rapidly ensuing. The patient was a boy who attempted suicide with a revolver discharged toward his heart. The first diagnosis was wound of the heart. The third and fourth ribs were immediately resected and the seat of the injury revealed. Suture seemed out of the question, because of the inaccessibility of the lesion. In von Eiselsberg's case, however, it had been possible to close the wound directly. This author first succeeded in clamping the bleeding vessel, after which he placed upon it a double ligature. Aside from the threatening heart failure, the chest symptoms were out of all proportion to the severity of the case, being almost absent. —*Medical Record.*

Catgut Sterilization.

Hutchings, in the *Annals of Surgery,* places raw catgut, without any previous treatment, in suitable tubes, which are left open, and put in an ordinary vacuum desiccator over sulphuric acid. The air is withdrawn from the desiccator until a pressure of less than four minims is secured. The connection between the desiccator and the pump is then closed, the pump removed, and the desiccator set aside for eight days. At the end of this period, air, dried if necessary by passing through a Wolff bottle containing sulphuric acid, is allowed to enter the desiccator. The tubes are removed and sealed, and are ready for sterilization. Any method of heating may be employed, but the author in his work used a mixture of glycerin and distilled water with a boiling point of 150° c., the container being fitted with a reflex condenser. The

sealed tubes are placed in the container and boiled for two hours. Experiments made with catgut impregnated with various bacilli showed that after this method of sterilization none of the catgut was contaminated. Control animals inoculated with the gut before sterilization died of the diseases.—*The Medical Brief.*

Correction of Nasal Deformities by Mechanical Means and by the Transplantation of Bone.

William Wesley Carter, New York (*Medical Record,* December 9, 1911), describes two methods which he has devised for the relief of deformities of the nose and of the nasal septum. He divides nasal deformities into those with and those without loss of bony tissue. In the former he employes the "bridge" splint, a hinged framework adapted to keep the tissues in place with the aid of internal molded rubber splints. These can be used wherever there is sufficient bony tissue to support the splints. The author has operated upon fifty patients by this method, including recent fractures, old, depressed, and irregular fractures, and lateral deformities. Great care should be used in the selection of cases. The bony framework should be thoroughly mobilized, and, if necessary, the septum lengthened; the wings of the bridge must be well padded with gauze and the skin on which they rest should be bathed with alcohol to prevent excoriation. In nasal deformities attended with loss of bone the author employs an autoplastic operation, transferring bone from the ninth rib of the patient to take the place of the bone that has been lost. He does not remove the periosteum with the bone, since he does not wish to produce new bone. This method is of great value in cured cases of syphilis in which nasal deformities are present. The introduction of the bone never causes any irritation and the wound quickly heals.—*The American Practitioner and News.*

Blue Light as an Anaesthetic.

More than thirty years ago there prevailed what was afterwards termed the blue-grass craze. All sorts of ailments were

thought to be amenable to the action of blue light, and the newspapers were filled with glowing accounts of cures. Enthusiasm ran riot for a time, and then the matter dropped out of sight. Quite some time later there was a revival of interest in phototherapy when Finsen demonstrated the curative properties of the ultra-violent ray in various affections, especially lupus. Since then the physiological action of light has been carefully investigated, and although much remains to be learned, there can be no doubt that we are nearer to an appreciation of its possibilities in the treatment of disease.

One of the most remarkable actions of light has recently come to our attention. In an address before the Boston Physio-Therapeutic Society Dr. E. C. Titus demonstrated that blue light possessed remarkable anesthetic power. In his experiments he used a series of slender glass rods about one-eighth of an inch in thickness, placed side by side and tied together so as to form a kind of flexible mat which will adapt itself to various parts of the body. The glass must be of cobalt blue and transmit no red rays, this being a very important point. The rods are to be placed upon the area to be anesthetized, and some form of white light, preferable a tungsten lamp, brought as closely as possible without causing discomfort. Strange to relate, in twenty minutes the part becomes insensitive, so that superficial and even deep incisions or punctures are no longer felt. This anesthesia lasts for one-half hour or more, and has occurred so constantly that there is no reason to believe that it is the result of suggestion or accident. Minor surgical operations have been performed under this method and without the least pain or discomfort, and there seems to be enough in it to merit attention.—*International Journal of Surgery.*

How Long Shall Patients be Kept in Bed After Operation?

Miller regards it as being probable that enthusiasm for early rising after operation has warped better judgment. Too little has been said in defense of conservatism along these lines. It

does not seem rational to him to demand added effort of an already heavily burdened patient. He emphasizes that when we ourselves are tired, we rest; when medical patients evidence fatigue, we insist on rest and quiet. In the treatment of exhaustion, injury or febrile conditions, we enforce, first of all, the rule of rest; we are therein frankly recognizing a law of nature. We can not make so critical a group of post-operative cases exempt from this law without incurring great risk. Rest is an essential element in post-operative care. The duration of its enforcement must be decided for each case as an individual, and not as a representative of this or that group, and in this decision there is frequently need for nice judgment. We can not reduce it to a rule of thumb.—*Journal of the American Medical Association.*

OBSTETRICAL

Puerperal Infection.

The number of cases treated by Watkins in the last two years has been seventeen. The treatment consisted chiefly in the use of measures to increase the body resistance and thus hasten "immunity." The remedies employed have been much the same as used in cases of tuberculosis to increase the physiologic resistance. The treatment consisted chiefly in: 1. Raising the head of the bed to promote drainage. 2. Putting an ice-bag on the abdomen. 3. Giving a large amount of nutritious, easily digested food. 4. Administrating at least two quarts of fluids daily and otherwise forcing elimination. 5. Keeping the patients out of doors a part of each day when possible and giving sunbaths. 6. Seeing that pain was relieved and that six to eight hours of sleep was obtained daily. The uterus was not disturbed except for hemorrhage or when a retained fetus, placenta, or decidua was known to be present. When present they were removed without the use of a an anesthetic and without producing much traumatism. When the cervix was not well dilated the uterus, cervix and vagina were packed with sterile gauze to promote dilatation,

to cause separation of the placenta or decidua, and to stimulate spontaneous expulsion.—*Journ. of the American Med. Assn.*

Means for Artificially Inducing Respiration in Infants and Young Children.

Ssokolow places the child on a table with the head hanging down over the edge. Then he lifts up the head, bending it down on the sternum, at the same time as he draws up the legs until the knees touch the region of the sternum. Repeating these movements rhythmically he has been able thus to recuscitate apparently asphyxiated infants and children with never a failure. He explains the mechanical principle involved as that the traction on the chest muscles pulls on the sternum and scapulæ as the head drops backward. This is the phase of inspiration, while expiration is induced as the head is doubled forward on the chest and the abdomen squeezed by the child's knees. Other important factors are the traction on the tongue and larynx and the flux and reflux of blood into the brain, acting on the respiration center both directly and by reflex action. He has found the method particularly useful in asphyxia during or after a tracheotomy operation. Two illustrations show the technic further. He adds that it is harmless for the child. There is no need for letting the child get chilled while it is being applied. It is not fatiguing for the physician, while it has the advantage over the Schultze method of the reflex action from traction on the tongue and larynx. Another advantage is that the head does not have to be held in the hand all the time.—*The Journal of the American Medical Assn.*

Total Hysterectomy in Tuberculous Pregnant Women.

It is generally admitted that if a tuberculous pregnant woman becomes rapidly worse in the early months of pregnancy, the latter should be terminated. The usual method is the artificial induction of abortion, but after the second month or thereabout the unfavorable result of the often copious and protracted hem-

orrhage must be borne in mind; and despite the care enjoined upon the husband in reference to the prevention of a further pregnancy such a contingency is very likely to happen. Hoehne, at a recent meeting of the Medical Society of Kiel (*Münchener medizinische Wochenschrift,* October 24) commended the practice under these circumstances of total vaginal hysterectomy, including ablation of the adnexa. The idea was first carried out by Bumm upon a series of women now aggregating twenty-six. The author has thus far operated three times, but in one case he performed a supravaginal abdominal hysterectomy, leaving the adnexa intact. Hemorrhage was less than in the average abortion. Further, as general narcosis is not always justifiable in pulmonary tuberculosis, the author preferred lumbar anesthesia. Again, in these cases removal of the ovaries so far from being harmful was believed to exert a favorable influence in tuberculosis. In any case, the latter disease showed quite a notable improvement as the joint result of interrupted gestation and castration.—*Medical Record.*

Eclampsia, the Blood Pressure Index of.

Triweekly blood pressure examinations, combined with the regular urine examinations for albumin and casts, offer the best safeguard, according to the studies of the author, against the unexpected occurrence of this affection. The average blood pressure in the last weeks of pregnancy is 118 mm. Fluctuations amounting to 30 mm. Hg above this need cause no alarm. Blood pressure over 150, however, should be thoroughly investigated at once.

The blood pressure in eclampsia with convulsions, though usually in the neighborhood of 200 mm. Hg, may be as low as 155 mm. Convulsions do not occur when the blood pressure is lowered by poor resistance, as in the so-called fulminant cases, or when lowered by veratum viride or other drugs producing collapse. Treatment should be directed not toward reducing the blood pressure, but to removal of the toxemia, for the rise of

blood pressure may denote only the resistance of the system toward the toxins.—*Monthly Cyclopedia and Medical Bulletin.*

Ozone and Fertility.

R. L. Hammond, Woodsboro, Md., says that ozone was formerly held in high esteem, and is, no doubt, a potent agent, exerting a triune meterological effect in the prevention, causation and cure of many diseases, particularly the epidemic and miasmatic varieties. Its history reveals many interesting opinions regarding its value in the animal economy. In "The Year Book of Treatment," 1892, p. 347, Lea Brothers & Co., I find the following, which will show the value placed upon it by some apparently competent observers: "Dr. Samuel S. Wallian (*New York Medical Journal,* 1891, vol ii, p. 101), makes some statements which, if correct, are important. He says that at Trincomalee, in Ceylon, from May to September, the southwest monsoon blows over the island, and in passing through the jungles gets robbed of its ozone. From October to April the northwest monsoon blows over the Bay of Bengal, and arrives at the village laden with ozone. From May to September the ozone was 2.5, and the number of conceptions 57; from October to April the ozone was 8, the number of conceptions 100. The Malagash negroes breathe a scantily ozonized air, and are noted for their want of fecundity; while on the east coast of Central America, and on the north side of Cuba and Jamaica, where the atmosphere is nearly always highly ozonized, large families and multiple births are quite the rule. He thinks there is no doubt that the free use of active oxygen has a marked influence over the procreative function. Patients who have regularly inhaled the artifically-prepared gas for some weeks or months, for various ailments, have almost invariably found themselves gradually recovering lost sexual tone to a decided degree. Numerous observers have corroborated each other on this point, and in nearly every instance the results noted have been wholly unanticipated. Cases of sterility have, under its use, recovered, and impotence of long standing has given place to a fair degree of virility. A physician of Dr. Wal-

lian's acquaintance, who has made extensive use of active oxygen in his practice, declares that he has but one objection to its use, which is, that it invariably arouses the sexual appetites of those patients who persist in its use for any considerable time."—*Virginia Medical Semi-Monthly.*

Repeated Cesarian Section on the Same Patient.

Mrs. E. S., aged 27, married four years, presented herself at the Methodist Episcopal Hospital three years ago, after being in labor 55 hours. She was a primpara with a justominor pelvis, into which the head refused to enter. Attempts at engagement were made under anesthesia, and tentative traction made with the forceps, which made the disproportion between the head and the pelvis apparent. A Cesarian was done and a 10¼ lb. child delivered. The recovery was uneventful.

Fourteen months later she again appeared in the same service at term. On abdominal examination, the child was found to be large. Previous experience guided us in deciding to deliver her by an elective Cesarian section, from which she recovered without complication, except for a fistulous tract running from the upper angle of the second wound into the structure of the abdominal wall, for a distance of two inches. Repeated carbolization of this tract failed to close it.

In March of this year she again returned in Dr. Polak's service, pregnant, and at full term, and a third Cesarian was done upon her by Dr. Holden, through a median incision, which included the umbilicus. The omentum, which was found adherent to the previous scars, had to be pushed aside in order that a uterine incision could be made in the fundus. With the consent of the patient and her husband, the tubes were excised at their uterine ends and sewn by their peritoneal envelop to the posterior surface of the uterus, after the method of Harris. The interesting point of this case was the condition of the former scars in the uterus, which were carefully examined and found to be firm and thick.—*Long Island Medical Journal.*

Sex Determination.

The subject of Sex Determination is in no way receiving less attention of the profession than its mother subject the gynæcology. Books after books have been written and not a day passes when we come across a new method of determining the sex. Some believe that the parental influence has much to do with the sex of the unborn, others explain their experiences of determining sex due to coitus after or before the menstrual period, and others say that the right and left ovaries determine the sex of the expected child. In short every one has his different theory based on his experiences of a small or great number of cases. Here is another theory advanced by Dr. Calhoun mentioned in his book Sex Determination and Its Practical Application, published by the Eugenica Publishing Company of New York. The theory itself is not a new one, but the practical side of it is interesting, and we shall be glad to know as to how it strikes our readers and how far they think it is practical.

The laws, as described by the author, are based on the theory that the left ovary of woman produces female offspring while the right ovary produces male offspring, and the gravitation determines to which side the spermatozoa go. If the mother wishes for a girl and continues persistently to remain on her left side for a few hours after the introduction of the fertilizing spermatozoa in the uterus and specially refraining from lying on her right side for at least twelve hours, then if she is normal she will give birth to a girl baby. If she wishes for a boy and continues persistently to remain on her right side for a few hours, but specially not lying on her left side for at least 12 hours after the introduction of the fertilizing spermatozoa in the uterus, if she is normal and carefully follows these directions she will give birth to a boy baby.—*Practical Medicine.*

Appendicular Abscess Followed by Phlebitis of External Jugular Vein.

Not finding the appendix easily, and being unwilling to break

up the adhesions about the cecum, Richards did not remove the appendix, but drained the abscess through the wound, sewing up the remainder of the incision. The drainage was free, and on the third day following the operation the temperature was normal, and the bowels had moved well. No untoward symptoms developed until the eighth day, when the temperature rose to 105 and the pulse to 140. There was also a chill. The drainage was free and there was no signs of extending peritonitis. The drainage had a fecal odor, but not more so than at the time of the operation, and there was no more fecal matter in the drainage. The patient complained of a stiff neck, with soreness in the left side of the neck. On the following day the pain in the neck was much more severe, so Richards examined this region more closely and found the external jugular hard like a cord, and very painful to the touch. Just above the clavicle there was some perivascular inflammation. Richards immobilized the head, and gradually the inflammation disappeared.—*The Journal of the American Medical Association.*

Hysteria and Malingering.

In a brief exposition of what he calls the phylogenetic or evolutional conception of hysteria, as being due to an exaggeration (or disorder) of tertiary (nervous) female sex characters, Weber endeavors to explain why hysteria (according to his conception of hysteria) is so frequently associated with a tendency to simulate disease, accident or injury, or deceive in some kind of way in the absence of any adequate (rational) motives. He claims that the so-called tertiary (nervous) female sex characters, though naturally best marked and most striking in the female sex, are not the exclusive property of the female sex. They occur likewise in the male, but are usually less conspicuous in the male sex, and it is only their occasional exaggeration (or disorder) that Weber explains the occurrence of hysterical and irrational (apparently motiveless) deception and simulation "hysterical malingering") in males. Teleology (that is to say, the modern Darwinic or evolutional idea of teleology) finds a place in the phylogenetic aspect

of hysteria and it seems to Weber also to claim a place in regard to other conceptions (Babinski, Freud, Janet and others) of hysteria. For instance, he asks, is it not conceivable that hysterical excessive suggestability may, on the whole, be useful rather than harmful for persons whose own will-power is pathologically deficient? Moreover, in cases in which wretched experiences have made their physical marks or "physical traumata" in the past and in which the present condition is in some way gravely affected by subconscious reminiscences, "separation of consciousness" may be supposed to bring not only inconveniences and dangers, but also a certain kind of relief.

Some functional nervous symptoms usually classed as hysterical are not readily explained by Weber's conception of hysteria. So-called "hysterical vomiting" seems to be a pathologically exaggerated action of the reflex defensive mechanism by which poisonous or irritating ingesta are normally rejected. But it may sometimes be on the borderland between hysteria and voluntary action simulating disease. Furthermore, Weber continues, in regard to the greater frequency of simulated diseases, self-inflicted skin lesions, etc., in women than in men it may be remembered that when a woman is depressed and altogether discontented with the life she has to lead, she is more likely than a man would be to try to attract attention or pity by simulating disease or injury. A man usually has much more open to him; he can seek a new country or (if he does not endeavor to obtain relief by drink or gambling) he can take part in dangerous ventures of various kinds which bring excitement and temporary relief.—*The Journal of the American Medical Association.*

Toxemias of Pregnancy.

S. H. Blodgett, Boston, Mass., speaks of two types of toxemia in pregnancy; the one of uremic nature and the other indicating imperfect pancreatic action. Uremic poisoning may develop slowly or rapidly. In slow poisoning there is greater danger to the child; in rapid poisoning there is greater danger to the mother. If nitrogenous food is not decreased in slow poisoning the ex-

cretion of urea gradually decreases. One should therefore limit the amount of nitrogenous food. If these cases are recognized early enough one need not order a strictly milk diet, but a large amount of liquid should be given. The amount of physical exercise should be limited, as exercise will often precipitate an attack of convulsions. The fetal heart beats should be watched carefully and if they weaken labor should be induced. In the rapid form of toxemia headaches, pains along the nerves and in the epigastrium, and loss of appetite come on suddenly, with scanty urine of high specific gravity. Labor should be induced at once. Pancreatic toxemia is characterized by nausea and vomiting, with diacetic acid and acetone in the urine. There is soreness on deep pressure over the head of the pancreas. The treatment is bicarbonate of soda given in daily doses of from 20 to 60 grains, with hot or cold water. *Medical Record.*

MEDICAL

The Tuberculin Reactions as Diagnostic Aids.

O. H. Benker, St. Louis (*Interstate Medical Journal,* December), has attempted to diagnose early or suspected cases of tuberculosis by noting the reaction to intradermal injections of tuberculin. His technique is as follows: The place of innoculation over the biceps muscle is cleaned with alcohol; then with a sterile platinum needle and glass syringe, the eye of the needle pointing upwards, inject 1-10 c.cm. of the following five solutions: Phenol ½ of 1 per cent, O. T. (Koch) 1-10,000 mgrm., O. T. 1-1,000 mgrm., O. T. 1-100 mgrm., O. T. 1-10 mgrm., at a distance of 5 cm. from each other, allowing the solutions slowly to infiltrate the skin, producing a small papule. A positive reaction takes place as a rule several hours after the innoculation to 1-10 mgrm. and 1-100 mgrm., and often also to 1-1,000 mgrm, and even to 1-10,000 mgrm., showing greater intensity to the stronger solutions. After twelve to twenty-four hours the infiltration becomes visible and palpable and the inflammatory reaction increases accordingly. At the end of forty-eight hours it has reached its greatest intensity. There may then be seen a small central tuber-

cle encircled with a zone of redness, shading off gradually into the healthy tissues. The reaction fades away, as a rule, after two days, but persists at times for several weeks. The control injection of ½ per cent phenol shows a slight erythema which becomes inperceptible after a few hours. A slight fever reaction is due to faulty technique in injecting some of the tuberculin subcutaneously instead of intradermally. The author, as the result of his experience with the method, draws the following conclusions: 1. That by the intradermal test, in doses from 1-10,000 to 1-100 mgrm., nearly all doubtful and early cases of tuberculosis can be demonstrated. 2. If, after a 1-10 mgrm, injection no reaction occurs, tuberculosis may be excluded. 3. From reaction to doses between 1-10 and 1-100 mgrm. the presence of a latent tuberculosis may be inferred.—*Interstate Medical Journal.*

The Adequate Treatment of Gonorrhea.

Thomas Wright Jackson, Fort Hunt, Va., states that the army and navy surgeon has a rare opportunity to observe the treatment of gonorrhea since on shore or at sea he has under his treatment a large number of men. As a result of his experience the author believes that there is no method of treating gonorrhea in a short time. A small percentage of cases are practically incurable; a much larger proportion of cases remain uncured because the patients will not submit to proper treatment. The total number of indefinitely infectious cases is very large. There is no proper test of cure except the microscopic examination. The complement-fixation test enables one to diagnose a number of cases that otherwise might escape detection. Persistence in whatever treatment is selected is the cardinal point in the successful management of these cases.—*Medical Record,* December 23, 1911.

Industrial Diseases Due to Metallic Poisons and the Measures Needed for their Prevention.

M. Allen Starr, New York, cites the large number of trades in which lead is used and shows that among employes of these

trades, lead poisoning manifesting itself all the way from lead colic to tremor and palsy, is very frequent. Chronic poisoning with lead also occurs from ingestion of small amounts, with a general state of malnutrition, pallor, anemia, and lack of physical and mental capacity. Neurasthenia, headache, and loss of sight from neuritis also occur in these cases. There are some 150 trades in which this form of poisoning is found, and it occurs in large numbers of persons. Arsenic poisoning occurs in 27 trades, the symptoms being insidious, and similar to those of lead poisoning in the chronic form. Mercury poisoning occurs in the manufacture of thermometers, barometers, incandescent lamps, etc. Phosphorous poisoning occurs in the manufacture of matches. The poisoning in all these forms is due to the inhalation of dust-laden air containing the poison, or of fumes when the metal becomes volatilized. The preventive precautions are very simple, yet they have not been put into use in this country. In England good laws have been enacted and enforced, with the result that industrial poisoning has been much reduced. The precautions are good ventilation, ample washing conveniences, the use of respirators when at work, and care not to eat without washing the hands. These are all easily possible of observance. One should start a campaign of education of employes and employers, and should secure legislation compelling precautions in factories.—*Medical Record,* February 3, 1912.

The Doctor's Dual Personality.

From a lay standpoint the doctor is a very inconsistent person, doing a great number of things which are entirely contrary to the fine line of precepts handed down to his patients. Just why it is that in his personal habits the doctor is so prone to disregard the excellent advice he gives his patients is from the layman's standpoint considerably more than a puzzle—it is a joke. It might be well for the medical profession in general if the laity understood a little better the underlying reasons for such apparent inconsistency, but the really genuine doctor never talks about himself, and especially his health, if he can possibly avoid it.

No one understands as the doctor does the results of morbid introspection. Wherever he goes, and as long as he practices his profession, the doctor is continually encountering the individual who would be in pretty good health if he or she thought so. So he would be, indeed, very obtuse if he didn't gather from these tiresome exhibitions constantly coming to his notice a valuable lesson for himself. He systematically ignores his own symptoms, unless they become a menace, in which case he promptly consults a colleague for the judicial counsel which no really ill person can provide for himself.—*Medical Review of Reviews.*

Use Common Sense in Infant Feeding.

During the last few years there has been a marked tendency by the medical profession to discard complicated formularies in infant feeding. This is indeed a welcome relief, as most of us have not forgotten our unnecessary expenditure of energy in acquiring this or that system of feeding. Americans have always been noted as faddists, and fall head over heels in adopting chimerical propositions set forth by leading lights without awaiting a thorough testing of new hypotheses. This characteristic had led them into many errors, in many instances to their sorrow. We have had somewhat the same experience in artificial feeding in babyhood. The modification of milk was carried to such limits that if it were not for the tragedy attached it would be laughable. In some instances the proteids, fats, etc., were so diluted that children were undoubtedly starved to death. All of us have no doubt seen children who were on the verge of death from inanition on modified diet as heretofore and even at present practiced immediately pick up and take on new life when a common-sense doctor order a discontinued fanciful modification and placed him on whole milk diluted one, two, three, etc., times, according to the indications of the case. As a matter of fact, we have been informed that teachers of pediatrics have almost entirely discontinued teaching their students systems for modification of this article of diet, and now impress upon the student the necessity of resorting to common sense in infant feeding. They have come

to realize that one child of a given age will thrive on whole milk, while another will need it decidedly diluted. There are no fixed rules, therefore, and each case must be studied individually. It has been found that the best procedure is to start the baby on whole milk diluted about four times and note how it thrives. If he manages such a dilution, but does not gain properly, then a larger feeding or a less dilute diet is ordered. We do not desire to convey the impression that scientific feeding has been without value, but that it has been carried in the past to ridiculous extremes. Undoubtedly, instances will still arise in which it can be employed satisfactorily, but the ordinary run of physicians will derive more satisfaction from the simple line of procedure outlined above.—*Maryland Medical Journal.*

A Method of Curing Corns.

In the method to be described, says the *Medical Summary,* the writer depends upon the macerating power of ordinary adhesive plaster to effect the result sought. A strip of this material from three-eighths to one-half of an inch in width and four to six inches long is to be applied in spiral fashion to the affected toe, covering the digit from neck to nail. The degree of tightness of the application deserves consideration to avoid compression. However, the feelings of the patient when stepping upon the foot will serve as an adequate guide in this matter. Given instructions to cut through the plaster lengthwise or to soak off the entire dressing by immersion in hot water foot bath afford ample protection in cases of undetected microbic infection. Soaking the foot from ten to twenty minutes in water at a temperature of 100 degrees with gentle removal of the crown of hardened epidermis, by rubbing with a piece of sterilized pumice stone or with forceps, shortens the time of treatment. Properly applied the plaster strap dressing described should afford relief from the moment of its application and may be worn continuously for from one to six or eight weeks—bathing seeming to unaffect the adhesive properties of the plaster after having once set. Removal of the dressing at the end of an adequate time reveals the corns completely

freed, when it may be picked out entirely by means of a dressing forceps or after an additional soaking. A wisp of absorbent cotton held on by means of a narrow adhesive strip may be subsequently worn for a few days.—*American Medicine.*

Heart Strain.

Heart strain in the aged has lately become of considerable importance, although it is an old subject in the medical world. The Surgeon General of the Army in his last annual report has called attention to the damage done to old hearts by endurance tests, and taken in conjunction with the sudden deaths alleged to have been due to the tests, this report leaves no doubt that the human frame can not possibly endure such strains after it begins the downward course after 45 or 40 years of age. Even 35 years, weakens some of the tissues so that they are dangerously strained by pressures harmless to the boy of 15 or 20. Hard daily training to keep in "condition" for muscular feats is therefore to be condemned after 35 or 40, but the exercise must be gradually lessened to keep below the danger line of tissues which are weakening as nature intended them to. Endurance lessens and we can not keep it. Our efforts only lessen it. The strenuous life after 40 is unnatural and dangerous, and after 60 is out of the question, except for a very few exceptional men who ought to be in better business anyhow.—*American Medicine.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

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All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

He Was First to Swat Flies.

Dr. A. B. Tadlock, who says he was the first to declare war against the house fly, is residing at the Columbian Hotel in Kansas City.

In the widespread cholera epidemic in 1873 in the United States, Doctor Tadlock, a practicing physician in Knoxville, Tenn., was called to Greenville to aid in fighting the cholera. He noticed that in localities most thickly infested with flies cholera cases were most numerous. After a time the flies died by thousands and disappeared, whereupon the cholera ceased.

Doctor Tadlock gathered up dead flies and examined them under a microscope. The President appointed a committee to report on the cholera epidemic. Doctor Tadlock accused the housefly of being largely responsible for the spread of the disease. Dr. Ely McClellan, U. S. A., chairman of the committee, called particular attention to Doctor Tadlock's theory, saying that he considered the idea plausible.—*Kansas City Times.*

Dr. A. B. Tadlock, so conspicuously mentioned in the above extract is known as one of the oldest physicians of Tennessee. He was born in Greene County, Tennessee, in 1836. Besides being known as a frequent contributor to our Medical Journal, and others, Dr. Tadlock was, in 1884, elected President of the Tennessee State Medical Society. He retired from the active practice of medicine about a quarter of a century ago, not so much

because of his age as by reason of blindness, the assigned cause being exposure and other effects as surgeon in the Civil War.

His discovery, above mentioned, has not only been accepted by the profession as a "plausible idea," but an established fact, and one of the most valuable factors in sanitation and the practice of medicine. The application of window and door screens and other devices instituted to fight the pestiferous housefly has become world-wide, amounting to great industrial importance. The effect, also, with the aid of the microscope, has been to implicate other insects (especially the mosquitos), in the nefarious work of scattering disease germs, notably typhoid, malaria and yellow fever, etc. As a result, yellow fever has been classed among the infectious instead of contagious diseases, and this is of great consideration and importance, commercial as well as medical.

To sum it up, the housefly has been in many places almost totally driven out and destroyed, with, as a consequence, sickness and death rates greatly diminished, noticeable recently in "summer complaint" of children. In a Kansas town, where the cold weather had killed the flies, there was immediate cessation of the disease.

A Liberal Proposition.

With this issue of the Journal we are sending sample copies to a long list of physicians in this State whom we are desirous of securing as new subscribers to one of the oldest and best independent medical journal published in the South—the *Nashville Journal of Medicine and Surgery*. In order to interest the profession and to secure the coöperation of physicians in building up our circulation into the thousands, we propose to present to every new subscriber of the Journal, an accurate clinical thermometer, tested and certified, self registering and with magnifying scale, in twisted aluminum case, chain and pin attached, for the subscription price of the Journal—$1.00—sent by check, registered letter or postoffice order. The retail price of the thermometer and case is $1.50, so that the new subscriber

gets for $1.00, subscription to the Journal for one year, beginning from the date of subscription, together with a handsome, reliable, clinical thermometer.

That our old friends, subscribers somewhat in arrears with their subscriptions, may not deem themselves slighted in this generous proposition, we make to them this proposition: To any subscriber, who, within the next sixty days from date of the issue of this Journal, sends in the amount of past due subscriptions, as per statements sent them with the beginning of this volume, we will send the thermometer, and receipt them for one year's subscription to the Journal from date of payment. We invite your attention to this proposition and hope you will, without delay, accept the offer and send in the money with your address. We want the support of every Southern physician as readers and contributors to the NASHVILLE JOURNAL OF MEDICINE AND SURGERY, one of the few remaining independent medical journals that is not bolstered up by the forced subscriptions of medical associations.

The New York State Civil Service Commission announces an examination to be held on February 24, 1912, for the position of Junior Physician (Homeopathic or Regular) in the New York State Hospitals for the insane, at a salary of $900 and maintenance, increasing $100 each year to a maximum of $1,200 and maintenance, beyond which point advancement is made upon promotion examinations. As the Commission has experienced difficulty in securing a sufficient number of eligibles from among residents of New York State, it has been decided to admit residents of other States, and in order to secure added competition, the Commission is endeavoring to make arrangements for holding this examination in Boston, Philadelphia, Washington, Cincinnati, Chicago, St. Louis and St. Paul.

The New York State Hospital service comprises fifteen State Hospitals, the Psychiatric Institute, and two hospitals for the criminal insane under the Superintendent of Prisons. Over 30,000 patients are treated annually, and the service presents the best available opportunity for the study of insanity. The insti-

tutions are organized along hospital lines, with training schools for nurses, and hospital equipment including laboratories, examination and treatment rooms and surgical operating rooms. There are nearly 200 salaried medical positions in the State Hospital service, and comfortable quarters, board and laundry are provided for all appointees and for the families of superintendents and first assistant physicians, in addition to the stated salaries. To those who take up the work as a career and apply themselves earnestly, promotion is certain and as rapid as is consistent with the period required for good training and maturity of judgment. The salaries of the higher positions are as follows: Assistant Physician, $1,200 to $1,500; Second Assistant, $1,500 to $2,000; First Assistant, $2,000 to $2,500; Superintendent, $3,500 to $4,500.

Anyone interested in this examination should write at once to the "New York State Civil Service Commission," Albany, N. Y., for application blank and full information.

N. B.—The New York State Civil Service Commission desires to give above notice as wide publicity as possible and requests that it be posted in medical colleges, etc., and especially that newspapers will publish the notice as an item of news.

JOHN C. BIRDSEYE, *Secretary*

Albany, N. Y., January 25, 1912.

New York, N. Y., February 9, 1912.—Dr. Charles S. Briggs, Editor Nashville Journal of Medicine and Surgery, Nashville, Tenn. Dear Sir: Your readers will be interested to know that Prof. Dr. Carl von Noorden, of Vienna, has accepted the invitation of the New York Post-Graduate Medical School and Hospital for a series of lectures on problems of Metabolism for October, 1912. Very truly yours,

L. KAST.

THE OVERLYING OF INFANTS.

We do not see much of this in America, but in England it has become quite a serious problem, both on account of the crowded

condition in which the poor of that country live and the excessive intemperance which exists among them, this accident is of very frequent occurrence. There have been laws passed in England to prevent parents sleeping with their infants, and societies formed to insure the prosecution of those who break these laws. Though this has done much good, there are still numerous instances of infant suffocation from overlying by either drunken or somnolent parents. A recent case before the coroner may be briefly related:

A man and his wife had spent the evening together, drinking, and both went home in a condition described in the testimony as follows: "The husband absolutely drunk and the wife not so drunk, but under the influence of drink." On their way home the man engaged in a street brawl, sending his opponent to the hospital. The husband and wife then went to bed, taking their month-old infant with them, and in the morning it was found to be dead. On the advice of the nurse the mother had purchased a cradle for the child, but for want of bedding it had stood unused, except by the cat. The coroners jury found that there was negligence, but not culpable negligence, and returned a verdict of "Death from Suffocation." The jury agreed that the parents had rendered themselves liable. The National Society for the Prevention of Cruelty to Children instituted proceedings in the police court and both father and mother were sent to prison for two months. The judge told them that they were lucky to escape a charge of manslaughter. Physicians can not be too diligent in warning their patients against this pernicious and dangerous custom.—*E. S. McK.*

The First Cesarean Section in America.

April 22, 1912, there will be a gathering of medical men at Newtown, Ohio, a suburb of Cincinnati, to erect a tablet to the memory of Dr. John L. Richmond, who, on the 22d of April, at that place, performed the first recorded Cæsarean section in America. The complete history of the case has been worked out with remarkable painstaking care by Dr. Otto Juettner, of Cin-

cinnati. His paper, read before the McDowell Medical Society of Cincinnati, was published in the *Cincinnati Lancet-Clinic* January 27, 1912. For reprint, write Dr. Otto Juettner, Birkshire, Cincinnati. The patient on whom Richmond operated was a young primipara, who lived in a log cabin, which had been hastily thrown together for immediate occupation, and was unchinked. The waters of the Ohio and the Little Miami had combined to make a flood apparently to stay the doctor on his errand of mercy. Nothing daunted, he procured a skiff and rowed to the isolated cabin, and there, with one assistant, a woman, whose duty was confined to holding the one candle and protecting it from the blasts which roared on the outside from putting them all in darkness. The report of the case made by Richmond, and published in *Drakes Western Journal of the Medical and Physical Sciences,* Vol. 1830, p. 435, and is quoted in full in Dr. Juettner's address previously mentioned. Dr. Richmond graduated from the Medical College of Ohio in its first class, 1822, practiced and preached in Newton, and went through the cholera epidemic in Cincinnati in 1831, contracting the disease himself. He removed to Indiana, living in Pendleton, Indianapolis and Covington. He died in 1855, and lies buried in Springdale Cemetery, Lafayette, Ind. A granddaughter still lives, who is the wife of the American Consul at London.

The *Alienist and Neurologist* for February, 1912, contains the following articles of merit by noted writers of the country on the different subjects: The Asexualization of the Unfit (Barr); Is Genius a Sport, etc. (Kiernan); Measurements and Anomalies (Macdonald); Real and Pseudo-Expert Medical Testimony Before Courts and Juries (Hughes); Notes of the History of Psychiatry (Jelliffe). The above original articles, together with a large number of judicious Selections,and the usual number of Editorials, Reviews, Book Notices, Correspondence, etc., make a magazine of unusual value to Alienists, Neurologists, Savants, Lawyers and the profession in general.

Anatomist (Male).
February 20, 1912.

The United States Civil Commission announces an examination on February 20, 1912, at the places mentioned in the list printed hereon, to secure eligibles from which to make certification to fill a vacancy in the position of anatomist (male), at $1,600 per annum, in the Army Medical Museum, Office of the Surgeon General, and vacancies requiring similar qualifications as they may occur, unless it is found to be in the interest of the service to fill the vacancy by reinstatement, transfer, or promotion.

The examination will consist of the subjects mentioned below, weighted as indicated:

Subjects	*Weights*
1. Normal histology and physiology	20
2. Pathologic histology	20
3. Gross pathology (including preparation of museum specimens	20
4. Bacteriology (including care and use of microscope)	20
5. Photomicrography	5
6. Training, experience, and fitness	15
Total	100

Applicants must have reached their twentieth but not thirty-fifth birthday on the date of the examination.

Men only will be admitted to this examination.

It is desired that the person appointed to this position shall be young, in good health, a graduate in medicine, have a thorough knowledge of pathologic histology, pathology, and bacteriology, be capable of making photomicrographs, understand microscopes, surgical instruments and appliances, and be able to prepare, card, and keep in order museum specimens.

All statements relating to training, experience and fitness are subject to verification.

In accordance with a recent act of Congress an applicant for this examination will be required to be examined in the State or

Territory in which he resides and to show in his application that he has been actually domiciled in such State or Territory for at least one year previous to the date of the examination.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application and examination Form 1312. No application will be accepted unless properly executed, including the medical certificate, and filed with the Commission at Washington. In applying for this examination the exact title is given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued January 15, 1912.

Attendance on Families of Medical Men.

A widow sold the practice of her lately deceased husband to a medical man, who went to reside in her house with a view of obtaining an introduction to the clientele. During his residence there he attended her cook and children professionally. Later a dispute arose as to the sale of the practice, and the widow brought suit to recover the purchase money. The defendant counterclaimed his fees for attendance. The plaintiff pleaded that it was the immemorial custom of the medical profession to attend the families of medical men without charge. Judge Scrutton said: "I am quite clear that although there is no binding

custom, there is a very general practice among medical men, to their honor, be it said, not to charge the widow and children of a recently deceased medical man for attendance. Where nothing was said there was an implied contract to pay a professional man his ordinary charges, that implication fell to the ground, where, according to the practice of the profession, the ordinary charges were not made." It will be seen that the learned judge did not extend the custom one inch beyond what was necessary to decide this case. He added: "I think that in a case like the present, if a doctor intends to charge he must say so, thus giving the patient the chance of declining his services and going to another doctor who will not charge." The judge's ruling could not be taken as an authority for the proposition that a medical man is bound, by custom, not to charge for the attendance upon a brother practitioner, his wife and family. If there is probability of abuse of this kindly custom he will do well to take the advice of the judge who tried this case.—*E. S. McK.*

Law Against Spitting in Austria.

Owing to the remarkable increase of tuberculosis in Austria, that government has passed a stringent law against expectorating in public places, making the fine 200 kronen, nearly forty dollars. The Austrian is, as a rule, a very easy going person, and it remains to be seen whether the law is enforced. Indeed it probably will not be, as the law has been promulgated for a year and not an arrest has been made. Experiments are under way in Austria to ascertain whether or not the dangers of promiscous spitting in public places are so great as generally believed. These tend to show that the danger is much greater from the saliva than from the dust in the railway carriages which are frequented by tuberculosis patients. In Winnipeg, Manitoba, there is a fine of fifty dollars for spitting on the sidewalk, and it is pretty well enforced. Even the four-year-old Winnipegger is trained to go to the gutter when he wishes to expectorate. It would seem that this fine was excessive. A ten-dollar fine would be sufficient, more likely to be enforced, and not such a hardship when enforced.—*E. S. McK.*

Professional Secrecy and Infanticide.

A young woman was charged with the wilful murder of her child. Dr. Richard Brew, who had previously attended the girl, was called as a witness. He stated that anything which he knew was of a purely confidential nature as a medical attendant and claimed privilege communication. On further questioning he said that what he knew occurred about six weeks before the alleged murder. His claims of privileged communication was allowed.—*E. S. McK.*

Reviews and Book Notices

Practical Electro-Therapeutics and X-Ray Therapy.—With Chapters on Phototherapy, X-Ray in Eye Surgery, X-Ray in Dentistry, and Medico-Legal Aspect of the X-Ray, by J. M. Martin, M.D., Professor of Electro-Therapeutic and X-Ray Methods in the Medical Department of Baylor University, in the Medical Department of Southwestern University, and in the State Dental College, Dallas, Texas; Member of the Texas State Medical Association, American Medical Association, American Röntgen X-Ray Society, etc., containing 219 Illustrations. St. Louis. C. V. Mosby Company, 1912.

We are indebted to the interprising publishers for a copy of this most valuable book. The author has succeeded admirably in presenting a book that will meet the wants of students and general practitioners in this progressive department of medicine in the most exceptional manner. It introduces only such features of the diagnostic and therapeutic work as will be of practical value to practitioners who have not time to devote to acquiring the requisite knowledge from more elaborate treatise o nthe subject. The work is well arranged and classified, and has been amply illustrated throughout. The use of the X-ray has of late become almost indispensible as a diagnostic agent, and its value as a therapeutic resource is becoming more generally recognized. We unhesitatingly commend the work to the profession as one that merits the fullest patronage of students and practitioners and feel sure that it will rapidly become popular with the medical profession.

Publisher's Department

Our readers will note in this issue for the first time the artistic advertisement of Palpebrine, the safe and reliable remedial agent in all external inflammation of the eyes. This product is manufactured by the Dios Chemical Co., who have, during the last quarter of a century, manufactured exclusively for physicians, Dioviburnia, Neurosine and Germiletum, the reliability of which is generally recognized.

No new and untried drugs enter into the composition of these specialties, and their formulae have always been communicated to the profession. Palpebrine will fill a long-felt want of the general practitioners, who can themselves treat with this product, safely and successfully, external inflammation of the eyes.

The Dios Chemical Co., of St. Louis, will mail free, trial bottle of Palpebrine on application.

Sodium Salicylate the Remedy for Rheumatism.

"When a diagnosis of rheumatism has been made, it then behooves one to cast about for some agent that will quickly arrest the process and avert complications. For this, one remedy stands out preëminently — namely, salicylates. Preference should be given the sodium salt. Some do not regard this favorably, and it is these who may have an instrument they do not know how to wield. Plehn has pointed out the "stumbling block" for these, showing that success depends upon adequace of dosage, and he further observes that the salicylates are as much a specific in acute articular rheumatism as quinine in malaria or mercury in syphilis."

"One strong objection advanced is the inability of the patient to retain the medication because of the nauseating effect. Sodium salicylate has a very sickening sweet taste and should never be administered except in the form of a solution."

The natural salicylic acid in Tongaline will not cause the disturbances that accompany the use of the synthetic product, which

is invariably dispensed unless the natural salicylic acid is specified. Hence Tongaline is a most desirable vehicle for the administration of natural salicylic acid.

Rheumatism.

These are few diseases in which Iodia is more servicable than rheumatism. In some of the chronic types, characterized by the depressing joint affections that make life a burden, Iodia will be found well-night a specific. It relieves pain and soreness in a manner quite remarkable, and gives the patient more comfort than has been known for months. Likewise, many of the myalgic forms respond at once to Iodia, and lumbago usually clears up rapidly under its use. Iodia does not conflict with other anti-rheumatic remedies. On the contrary, it is a powerful synergist and greatly augments the action of the salicylates and similar remedies. Iodia should be given in two teaspoonful doses three or four times a day.

Notwithstanding the large number of Hypophosphites on the market, it is quite difficult to obtain a uniform and reliable syrup. "Robinson's" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including iron, quinine and strychnine, etc., in perfect solution, and is not liable to the formation of fungus growths.

Contents for February, 1912

ELEGANT
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NUTRITIVE, TONIC, ALTERATIVE.

A STANDARD REMEDY in the treatment of Pulmonary Phthisis, Bronchitis, Scrofulous Taint, General Debility, etc. Stimulates Digestion, promotes Assimilation.

℞ Each fluidounce contains:

Hypophosphites Soda - - - -	2	grains
" Lime - - -	1½	"
" Iron - - - -	1½	"
" Quinine - -	¾	"
" Manganese -	1½	"
" Strychnine -	1-16	"

DOSE—One to four fluidrachms.

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Powder in 1-oz. vials, dose 10 grains, 4 times daily (under physicians prescriptions), per 100 $1.25.

Tablets, 5 grains, to a bottle, dose, 2 tablets 4 times daily (under physicians prescriptions); per 100, $1. 5.

Elixir, in 16 ounce bottles, dose, teasponful after each meal and at bedtime (under physicians' prescriptions), per bottle $2.00.

Physicians who have used Saloform are enthusiastic in their praises of its merits.

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Albuminate of Iron is a definite chemical compound of albumen and Iron. In the manufacture of the preparations of this iron salt, we use fresh egg albumen only. Albuminate of Iron is the organic compound present in the red corpuscles of the blood. **It does not disturb digestion, neither does it constipate.** Contains in each teaspoonful one grain of the Iron salt, and itis perfectly stable and bland. Clinical experience has demonstrated its superiority as a chalybeate.

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Represents the digestive properties of the freshly extracted juice of the pineapple (Ananassa Sative) and other enzymes.

Each tablespoonful should digest eight ounces of albumen, meat fibrin or casein.

Pinozyme presents no incompatibilities with the gastric or intestinal secretions, and is a true digestant, which being active in either acid or alkaline menstruum, exerts its digestive properties throughout the entire alimentary tract.

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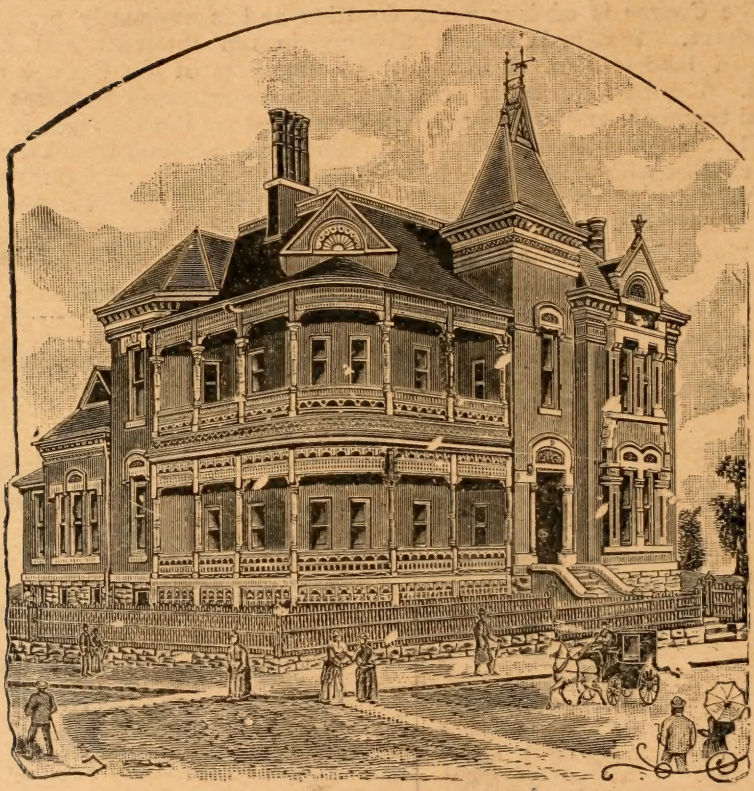

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